NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) PREMIUM SHARING DEMONSTRATION PROJECT

PREAMBLE

1. Sections Affected — Rulemaking Action

R9-30-101	New Section
R9-30-102	New Section
R9-30-103	New Section
R9-30-104	Reserved
R9-30-105	Reserved
R9-30-106	New Section
R9-30-107	New Section
R9-30-201	New Section
R9-30-202	Reserved
R9-30-203	Reserved
R9-30-204	New Section
R9-30-205	New Section
R9-30-206	New Section
R9-30-207	New Section
R9-30-208	New Section
R9-30-209	New Section
R9-30-210	New Section
R9-30-211	New Section
R9-30-212	New Section
R9-30-213	New Section
R9-30-214	Reserved
R9-30-215	New Section
R9-22-216	New Section
R9-30-217	New Section
R9-30-301	New Section
R9-30-302	New Section
R9-30-303	New Section
R9-30-304	New Section
R9-30-305	New Section
R9-30-306	New Section
R9-30-401	New Section
R9-30-402	Reserved
R9-30-403	New Section
R9-30-404	New Section
R9-30-405	New Section
R9-30-406	New Section
R9-30-407	New Section
R9-30-408	New Section
R9-30-409	New Section
R9-30-501	Reserved
R9-30-502	New Section
R9-30-503	Reserved
R9-30-504	New Section
R9-30-505	Reserved
R9-30-506	Reserved
R9-30-507	New Section

R9-30-508	Reserved
R9-30-509	New Section
R9-30-510	New Section
R9-30-511	New Section
R9-30-512	New Section
R9-30-513	New Section
R9-30-514	New Section
R9-30-515	Reserved
R9-30-516	Reserved
R9-30-517	Reserved
R9-30-518	New Section
R9-30-519	Reserved
R9-30-520	New Section
R9-30-521	New Section
R9-30-522	New Section
R9-30-523	New Section
R9-30-524	New Section
R9-30-601	New Section
R9-30-602	New Section
R9-30-603	New Section
R9-30-701	New Section
R9-30-702	New Section
R9-30-703	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2923 Laws 1997, Ch. 186 §§ 3 to 8, as amended by Laws 1997, 2nd Special Session, Ch. 186 §§ 3 and 4.

   Implementing statute: A.R.S. § 36-2923 Laws 1997, Ch. 186 §§ 3 to 8, as amended by Laws 1997, 2nd Special Session, Ch. 186 §§ 3 and 4.

3. **The effective date of the rules:**

   February 1, 1998

4. **A list of all previous notices appearing in the Register addressing the exempt rule:**

   Not applicable.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson, Federal and State Policy Administrator

   Address: 801 East Jefferson
   Mail Drop 4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**

   A.R.S. § 36-2923 and Laws 1997, Ch. 186, §§ 3 to 8, as amended by Laws 1997, 2nd Special Session, Ch. 186, § 3 and 4, gives AHCCCS the authority to establish the Premium Sharing Demonstration Project (PSDP) program. This is a pilot program that begins on February 1, 1998, and terminates on September 30, 2000. This program was designed to provide health care benefits to uninsured individuals. This program will help individuals and families get affordable medical coverage. Laws 1997, Ch. 186 § 7 exempts AHCCCS from the normal rulemaking process.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

   There will be a limited impact on AHCCCS for the cost of providing monitoring and support to the PSA.

   There will be a nominal impact on local DES offices and community health centers for making applications available to the general public.

   The following entities will benefit from the PSDP:

   - Premium share members because they will have access to affordable health care they would otherwise not have.

- PSDP contractors and PSDP health care providers because they will have additional health care business.

9. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Not applicable.

10. A summary of the principal comments and the agency response to them:
The Administration received comment from 5 entities. Their comments and the Administration's response is detailed below:

Rule Citation: R9-30-101

Comment: Where is the definition of "Practitioner"?

Response: Revised Article 1 to include the definition of "Practitioner".

Rule Citation: R9-30-102

Comment: Please add "HIV" next to acquired immunodeficiency syndrome under the list of chronic diseases. Under the definition of "chronically ill persons" the proposed plan contract ties eligibility to person receiving health care services under A.R.S. § 11-297 (as opposed to those who are merely eligible for such services). Should the same change occur here?

Response: Rule language was revised to add "HIV" to the list of chronic diseases.

Rule Citation: R9-30-102(1)

Comment: Will there be a ICD-9 cross walk for these?

Response: No, there will be no cross-walk available at this time.

Rule Citation: R9-30-102(2)

Comment: What is the reference to "12 out of 15 consecutive months..." mean?

Response: This means out of 15 consecutive months immediately preceding the date of application for the PSDP that an individual applying for coverage under the chronically ill program must have been eligible for services under A.R.S. § 11-297 (MI/MN) for 12 consecutive months.

Rule Citation: R9-30-103

Comment: "Premium Share Member" means an enrollee and members of the household unit who are enrolled with a plan. This is unclear, does this mean one individual or could it mean an entire family?

Response: Revised the definition of "Premium Share member" to make the definition more clear, concise and understandable. The definition now reads: "Premium Share member" means any member of the household unit who is enrolled in the PSDP.

Rule Citation: R9-30-201(A)(1)

Comment: If the coverage is only for diagnosis mentioned in the first section, shouldn't that be reiterated in this sentence for clarification? Or are all services available to members made eligible because of their chronic condition?

Response: The general requirements apply to all Premium Share members whether chronically ill or not.

Rule Citation: R9-30-201(A)(1)(a)

Comment: This sentence is very hard to understand.

Response: This subsection means that behavioral health screening and evaluation services do not require a referral from a PCP. However, behavioral health treatment services either require a referral or authorization from the contractor.

Rule Citation: R9-30-201(A)(1)(b)

Comment: Behavioral health evaluations covered without a referral from a primary care physician but treatment not covered without a referral. There should be some time constraint that allows treatment with a follow-up referral, that is, referral within 72 hours of treatment. This does not seem adequate as it stands. Emergency treatment may be required and it may not be possible to obtain a referral prior to treatment.

Response: No change to rule language. This issue is addressed in R9-30-210(D) which allows for consultation by a psychiatrist or psychologist if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

Rule Citation: R9-30-201(A)(1)(b)

Comment: Does behavioral health treatment require only a referral, or a referral and an authorization?

Response: They require a referral from the PCP or authorization by the contractor or designee.

Rule Citation: R9-30-201(A)(2)

Comment: Behavioral health services are limited to 30 days of inpatient and 30 days of outpatient visits annually as specified in Laws 1997, Ch. 186 § 3. Will ComCare be responsible for this coverage, or will the health plan?

Response: The health plans are responsible for this coverage. However, the health plans may decide to contract with any entity, such as ComCare to provide services.

Rule Citation: R9-30-201(A)(4)

Comment: This sentence is grammatically incorrect - recommend they use the wording from R9-22-203(A): "Services determined by the Director to be experimental or provided primarily for the purpose of research" shall not be covered.

Response: Revised the rule language as suggested.

Rule Citation: R9-30-201(A)(8)(b)

Comment: Patient in TB institution not covered? Why: Are there any TB institutions still in existence? If not, then this is an unnecessary rule.

Response: No change to rule language. This is consistent with AHCCCS Acute rules and federal law.

Rule Citation: R9-30-201(C)

Comment: This sentence should clarify that emergency services do require notification - or at least refer the reader to R9-30-210(C).

Response: Revised the rule language to read: "Emergency services under A.R.S. § 36-2908 do not require prior authorization, however, the member must notify the contractor as required in R9-30-210(C)."

Rule Citation: R9-30-201(D)(1)

Comment: A primary care provider refers a Premium Share Member out of the contractor's area for medical specialty care. This would normally require an authorization from the health plan. Without control of these referrals could place the management of these members in jeopardy.

Response: A referral must be submitted to the contractor.

Rule Citation: R9-30-201(G)

Comment: Out of area treatment is at discretion of Director. Based on what criteria will decisions be made? This seems like a bad idea, without some written criteria.

Response: No change to rule language. The rule states: "Criteria considered by the Director in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness."

Rule Citation: R9-30-201(I)

Comment: Providers who provide non covered services will not be able to use this factor in negotiations for capitation or contracts. These might be needed services for patient. What incentive is their for provider to provide adequate care for patients?

Response: No change to rule language. Capitation rates are developed based on covered services and the number of members who use these services. Contractors do not pay for non-covered services.

Rule Citation: R9-30-205(B)(2)

Comment: If a physical exam is the only barrier to a Premium Share member getting a job, shouldn't it be covered?

Response: No change to rule language. Laws 1997, Ch. 186 § 3 refers to the Acute covered services statute A.R.S. §36-2907. This is not a covered service in the acute care program.

Rule Citation: R9-30-205(B)(2)(b),(e),(f)

Comment: All sections should allow for coverage for physical exams for patients for pre-employment testing, disability evaluation and 3rd-party liability issues. I would think this would save state money in long run. Part of Empower logic is to help people advance themselves.

Response: No change to rule language. Laws 1997, Ch. 186 § 3 refers to the Acute covered services statute A.R.S. §36-2907. This is not a covered service in the acute care program.

Rule Citation: R9-30-205(B)(4)

Comment: Some "elective" surgeries are very important, for example, gall stones; colen polyps; CABG;s, etc.

Response: No change to rule language. If "elective" surgeries are deemed medically necessary they would be covered.

Rule Citation: R9-30-205(B)(4)(c)

Comment: Please consider the following: "Elective abortions unless medically necessary for the health and safety of the mother."

Response: Revised rule language to include the statute citation.

Rule Citation: R9-30-206(B)

Comment: If the member is a candidate for a heart transplant, and needs a mechanical heart to keep him or her alive until a donor is available, and you deny it - your publicity will be terrible.

Response: No change to rule language. Laws 1997, Ch. 186 § 3 refers to the Acute covered services statute A.R.S. §36-2907. This is not a covered service in the acute care program.

Rule Citation: R9-30-209

Comment: Will the health plans be allowed to develop their own formularies?

Response: Yes.

Rule Citation: R9-30-209(C)

Comment: Please consider adding the following at the beginning of this paragraph: "Subject to the contractor's formulary or authorization requirements."

Response: Revised the rule language to add the following to the end of the Section (C): "or designee's formulary".

Rule Citation: R9-30-210(C)

Comment: Would like the following language added to the end of the 1st sentence: "unless medically incapable of doing so."

Response: Added the following language to the end of the 1st sentence: "If a Premium Share member is incapacitated, the provider is responsible for notifying the contractor."

Rule Citation: R9-30-210(C)

Comment: The member is responsible for notifying the contractor after emergency treatment or emergency behavioral health treatment. This might be difficult for individuals under those circumstances and if not done in 48 hours then services not covered. The provider should be responsible for notifying the contractor to ensure payment.

Response: The rule language was revised to clarify that if a member is incapacitated, the provider would be responsible for notifying the contract within 48 hours.

Rule Citation: R9-30-210(C) and R9-30-210(E)(1)

Comment: Contradict each other. The 1st 1 says that the member must notify the plan within 48 hours, but the 2nd 1 says that the provider must notify within 12 hours - which is it? Or is it both? If both, then what are the consequences of each? If the member does not call within 48 hours, does he pay the bill?

Response: One is the responsibility of the member and the other is the responsibility of the provider. If notification of either 1 is not provided as required, the contractor may deny the claim.

Rule Citation: R9-30-211(A)

Comment: Under paragraph 2, after the word "transport", the rest of the sentence should read, "is justified as an emergent or a medically necessary ambulance transport."

Under paragraph 3, add the words "emergent or" prior to "medically necessary."

Response: Revised the rule language to add the words "or emergency" after medically necessary in the 1st sentence.

Rule Citation: R9-30-211(A)(3)

Comment: Determination of whether transport is medically necessary shall be based upon the medical condition of the Premium Share member at the time of transport. Who will be making this determination; member, health plan, transportation company, physician?

Response: The member will make the determination. The health plan can review based on the requirements in Sec 1932 of the balanced budget act.

Rule Citation: R9-30-211(B) and R9-30-217(C)(2)(f)

Comment: It sounds like non-emergency, but medically necessary transportation is not covered (per R9-30-211). R9-30-217 says that "transportation" is covered for behavioral health. Perhaps clarification is necessary in both sections.

Response: Revised the language to add the word "emergency" before "transportation".

Rule Citation: R9-30-212(G)(1),(2)

Comment: What will become of the durable medical equipment after need is completed? Will the contractor be able to resale the equipment or reissue it to patients? This needs more detail and fleshing out. The state stands to lose money if contractor keeps item after purchase. Maybe a giant surplus warehouse could be obtained and equipment kept and maintained by the state.

Response: No change to rule language. The contractor shall retain title to purchased DMS supplied to a Premium Share member who becomes ineligible or no longer requires its use. This equipment is generally reusable by others. As far as a surplus warehouse is concerned, there is not an appropriation by the Legislature to manage this.

Rule Citation: R9-30-212(G)(3)

Comment: If customized durable medical equipment is purchased by the contractor for a Premium Sharing member by the contractor, the equipment will remain with the person during times of transition, or upon loss of eligibility. They are concerned about the abuse of this provision, for example: a member could enroll for 30 days receive a $6000 customized wheelchair and drop the program the following month. This language needs to address this potential "loop hole" in the language before it is finalized.

Response: No change to rule language. This is a pilot program. If it is adopted as a permanent program, any "loop holes" that are identified will be addressed at that time.

Rule Citation: R9-30-213(A)(5)

Comment: Add the words "medically necessary" before "orthognathic".

Response: No change to rule language. All services shall be medically necessary. R9-30-201(A)(1) applies to all covered services.

Rule Citation: R9-30-215(B)(1), (2)

Comment: Occupational and physical therapy all necessary for full rehabilitation for a variety of physical conditions. In the long run if these services are provided during rehabilitation they will save the state money as patients hopefully would be able to re-enter the work force. Without therapy patients could end up on Long Term Care.

Response: No change to rule language. The Contractor shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation. Occupational and speech therapies are only covered on an inpatient basis for those 21 and over; physical therapy for all members and occupational and speech therapies for those under 21 are covered on both an inpatient and outpatient basis if not used as a maintenance regimen.

Rule Citation: R9-30-216(C)

Comment: Wording is confusing.

Response: Rule language was revised to be more clear, concise, and understandable.

Rule Citation: R9-30-217

Comment: Limit of 30 inpatient and 30 outpatient visits - is this the life time, or calendar year, or Administration's fiscal year?

Response: This is calendar year. Refer to the definition of "day" in R9-22-101.

Rule Citation: R9-30-217(C)

Comment: Under paragraph 2, transportation services in conjunction with behavioral health services should be limited to emergency ambulance services.

Response: No change to rule language. Emergency transportation for behavioral health services is covered as specified in contract.

Rule Citation: R9-30-301(C)

Comment: What is the purpose of the Health History Questionnaire? There is no provision in the rest of the provided regulations that allow for the application of pre-existing exclusions or any sort of underwriting. This needs to be expanded or cleared up. Otherwise, the questionnaire seems to represent an administrative technicality that a plan can use to refuse coverage of an enrollee. Or, is it the vehicle through which a health plan can determine how many members it has that apply to the chronically ill cap? Either way it is very unclear and would have a big impact on the medical risk profile the plan assumes (since the benefit can't be medically underwritten).

Response: The Health History Questionnaire is for medical management purposes only and is completed after a mem-

ber selects a health plan. There are no pre-existing condition exclusions or limitations for the PSDP. Also, since eligibility and enrollment are done by the PSA, a plan cannot refuse to cover an enrollee. Information from the questionnaire will be aggregated and reviewed by Legislative Counsel as a component of data retrieval required by the oversight committee to evaluate the program/pilot.

Rule Citation: R9-30-301(D)

Comment: The cap on chronically ill is unacceptable. Though their cost of care may be greater they are among those with the most need.

Response: No change to rule language. The cap on the number of chronically ill is explicitly stated in Laws 1997, Ch. 186, § 3 and 4.

Rule Citation: R9-30-303(C)

Comment: The PSA won't be determining eligibility for Title 36 or Title 11 programs. Why should they screen for these programs? Using applicant's declaration that they are not eligible for those programs is probably not the most reliable source.

Response: The PSA does screen the applications to ensure the applicant meets the eligibility requirements as specified in Laws 1997, Ch. 186 § 3 & 4, as amended by Laws 1997, 2nd Special Session § 3 & 4.

Rule Citation: R9-30-404(B)(2),(3)

Comment: If there is no requirement to notify AHCCCSA of subcontracted amendment, termination or assignment in Health Care Group rules, then no such requirement should be here.

Response: No change to rule language. These requirements can be found in R9-27-403(B)(1) and (2).

Rule Citation: R9-30-502(B)(1)

Comment: The required ratio of PCP's is not in the most recent PSP-health plan contract.

Response: Revised the rule language to allow a ratio to be reflected in contract. Currently, there is no ratio requirement, however, this may be modified in the future.

Rule Citation: R9-30-518(A)

Comment: We are willing to provide member information in English and Spanish; however, the 5%, 200-member requirement is burdensome and, if it remains, will need clarification; namely is it based on all PSP members or those in each particular plan?

Response: The rule language was changed to reflect current HCG requirements (R9-27-509).

Rule Citation: R9-30-518(D)

Comment: Conceptually, we think advance approval of marketing materials is a legitimate regulatory oversight; however, as we expressed in our comments to AHCCCSA on the proposed marketing policy, informational and educational materials may be unduly restricted through this process. Moreover, we are potentially creating a situation where OMC, HCGA, and PSA could arrive at conflicting decisions over the same material.

Response: The PSA will approve the marketing materials.

Rule Citation: R9-30-701(C)

Comment: Chronically ill individuals between 200-400% Federal poverty guidelines will pay the full premium. Do we know what the average premium cost is for the designated test areas?

Response: The premium is the same for all counties.

Rule Citation: R9-30-701(E)

Comment: Why do they have to pay premiums at least 30 days in advance? This seems like undue burden on clients

that can least afford it. Isn't there better technology to monitor the system for payments so that payments could be made at the 1st of the covered month and still be credited to patient account? The population that the plan hopes to service, historically lives paycheck to paycheck.

Response: No change to rule language. The premium payment is required in advance to allow sufficient time for the PSA to notify the health plan; for PSA to generate a bill for premium payment; and for the Health Plan to send a member handbook to the Premium Share member prior to the enrollment effective date. The law mandates an aggressive disenrollment process for members who fail to pay the required premium payment.

Rule Citation: R9-30-701(E)(2)

Comment: Premium paid with sufficient funds. This area describes how the member's premium are paid, but does not discuss what happens if the personal check from the member is returned to the PSDP.

Response: R9-30-305(A)(4) states a Premium Share member may be disenrolled for 2 submissions of a returned check.

Rule Citation: R9-30-701(F)

Comment: Copayment requirements. There are numerous copays listed for different services. The number of different copays will be difficult to administer and load into a payment system. A procedure of what kind of copay for what services needs to be presented as well (there is no criteria to determine if certain services override other services as far as payment of copays).

Response: The copayments are required by law

Rule Citation: R9-30-701(G)

Comment: Denying access to health care in non-emergent situations does not seem like a good idea and may up the use of hospital ER's across the states. Client will use ER as a primary care coordinator. It would be more cost effective to identify urgent versus emergent care and cover both appropriately.

Response: Premium Share members must pay a $50 copay each time they present to an emergency room. They should contact their plan or provider for non-emergent care.

Rule Citation: R9-30-701(G)

Comment: Withhold of services. How is the facility to approach payment of copay? Ask prior to services? This seems unfair to the facility to be placed in a "turn-away" situation.

Response: Since co-pays are a portion of the providers payment, it's up to the provider if they want to provide coverage without a co-pay. However, the Plan will not reimburse the provider for the uncollected co-pay.

Rule Citation: R9-30-702(A)

Comment: PSA's liability. I understand that services are to be for the completion of a plan of treatment. There is no provision to limit the Health Plans responsibility to limit services for only the "actual" enrollment segment.

Response: The health plans are required to provide covered services to Premium Share members as long as they are enrolled in the PSDP as specified in R9-30-201(F).

Rule Citation: R9-30-702(F)

Comment: Medical Financial Risk. The provision states limiting the risk. I assume this is for high dollar (reinsurance) cases. What is the limit?

Response: This section discusses the reconciliation process that will take place the 1st year so that the Plans are not at risk.

Rule Citation: R9-30-702(I)

Comment: What if the member goes to a non-contracted emergency room - what obligation does the hospital have for accepting the discounted rate as payment in full? This was an argument brought up when Health Care Group was around.

Response: Refer to R9-30-703(C)(2)(a) through (e).

Rule Citation: R9-30-702(I)(3)

Comment: Charges of claims. Section (I)(3) states payment of actual, and reasonable services. What is the reference of actual and reasonable (what are the standards to compare the services against?)

Response: No change to rule language. This is the same language used in the Acute Care program.

Rule Citation: R9-30-702(J)

Comment: Collection of payment. What assistance will the Health Plan receive for the providers who insist on balance billing for additional reimbursement?

Response: There is no balance billing for reimbursement.

Rule Citation: R9-30-703

Comment: Does the Health Plan submit an Explanation of Benefits to the member?

Response: This is not a requirement of the PSDP at this time.

Rule Citation: R9-30-703(B)(1)(c)

Comment: Is there any way that this can just simply state the time-frame, instead of forcing the reader to look up a reference that may not be available?

Response: The rule language in this subsection was revised to be more clear, concise, and understandable. The statutory reference was added as well. We believe it is easier for the user's of this rule language to know the requirements are the same as required for the Acute plans.

Rule Citation: R9-30-703(B)(2)

Comment: Claims submission. Shouldn't the area read; Clean claims are to be submitted within 6 months from the date of service; claim resubmission (nonclean claim) be submitted within 12 months from the date of service.

Response: No change to rule language. This section is discussing when a contractor is not required to pay a claim.

Rule Citation: R9-30-703(B)(5)

Comment: The wording "denial and rights of a claimant" is not grammatically correct. Suggest "denial of claim and the rights of a claimant". The wording should be "within 60 days of receipt of a valid claim" per R9-22-705(B)(1).

Response: Revised the rule language to be more clear, concise, and understandable.

Rule Citation: R9-30-703(C)(1 through 4)

Comment: Coordination of benefits. The enrollment section states that his plan will not normally be allowed or selected for members with COB, but in only a few cases. Is it to be assumed that the few cases that these services are to be as if last resort? If so, on the SOBRA exclusion, isn't AHCCCS to be the last resort?

Response: Yes, AHCCCS is always the payor of last resort.

Rule Citation: R9-30-703(C)(3)

Comment: Observation days. Is Health Plan responsible for the lesser of the 2 charges?

Response: The rule states that a contractor will reimburse at a rate specified by subcontract or in the absence of a subcontract, the AHCCCS hospital-specific outpatient costs-to-charge ratio multiplied by covered charges. It is either 1 or the other.

Rule Citation: R9-30-703(C)(5)

Comment: Out-of-state facilities. Eighty percent of billed charges is a high amount. Is this flexible since most out-of-state facilities are non-contracted?

Response: The rule states the lower of the negotiated discounted rates; or 80% of billed charges. This is consistent with the HCG rules (R9-27-703(D).

Rule Citation: R9-30-703(D)(2)

Comment: Is this 31 calendar days?

Response: Yes. This is specified in the definition of "day" in R9-22-101.

Rule Citation: R9-30-705(B)(5)(a), (b)

Comment: "Grieve the contractor's rejection..." and "submit a grievance" are the same thing, this is duplicative.

Response: Revised the rule language to be more clear, concise, and understandable.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **Was this rule previously adopted as an emergency rule?**
No.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) PREMIUM SHARING DEMONSTRATION PROJECT

ARTICLE 1. DEFINITIONS

Section
R9-30-101. Location of Definitions
R9-30-102. Scope of Services Related Definitions
R9-30-103. Eligibility and Enrollment Related Definitions
R9-30-104. Reserved
R9-30-105. Reserved
R9-30-106. Grievance and Appeals Related Definitions
R9-30-107. Payment Responsibilities Related Definitions

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements
R9-30-202. Reserved
R9-30-203. Reserved
R9-30-204. Inpatient General Hospital Services
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation Services
R9-30-207. Dental Services
R9-30-208. Laboratory, Radiology, and Medical Imaging Services
R9-30-209. Pharmaceutical Services
R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services
R9-30-211. Transportation Services
R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-30-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
R9-30-214. Reserved
R9-30-215. Other Medical Professional Services
R9-22-216. Nursing Facility Services
R9-30-217. Behavioral Health Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements
R9-30-302. Submission of Application
R9-30-303. Eligibility and Ineligibility Criteria
R9-30-304. Enrollment
R9-30-305. Disenrollment
R9-30-306. Redetermination

ARTICLE 4. CONTRACTS

R9-30-401. General Provisions
R9-30-402. Reserved
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ARTICLE 1. DEFINITIONS

R9-30-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 30 are found in the following:

1. "AHCCCS" R9-22-101
2. "Ambulance" R9-22-102
3. "Applicant" R9-30-101
4. "Chronic disease" R9-30-102
5. "Chronically ill person" R9-30-102
6. "Clean claim" A.R.S. § 36-2904
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9. "Copayment" R9-30-107
10. "Covered services" R9-30-102
11. "Day" R9-22-101
12. "Date of application" R9-30-103
13. "Eligible for AHCCCS benefits" R9-30-103
14. "Emergency medical services" R9-30-102
15. "Enrollee" Laws 1997, Ch. 186 § 3
16. "Enrollment" R9-30-103
17. "E.P.S.D.T. services" R9-22-102
18. "FPL" R9-30-103
19. "Fund" A.R.S. § 36-2923
20. "Grievance" R9-30-106
21. "Head of household" R9-30-103
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23. "Household income" R9-30-103
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37. "Practitioner" R9-22-102
38. "Premium" R9-30-107
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40. "Premium share" R9-30-107
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42. "Pre-payment" R9-30-107
43. "PSA" R9-30-101
44. "PSDP" R9-30-101
45. "Pre-payment" R9-30-107
46. "Prescription" R9-22-102
47. "Primary care provider" R9-22-102
48. "Prior authorization" R9-22-102
49. "Providers" A.R.S. § 36-2901
50. "Quality management" R9-22-105
51. "Redetermination" R9-30-103
52. "Referral" R9-22-101
53. "RFP" R9-22-105
54. "Service area" R9-27-101
55. "Scope of Services" R9-22-101
56. "Subcontract" R9-22-101
57. "System" A.R.S. § 36-2901
58. "Utilization management" R9-22-105

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Applicant" means a person who submits, or on whose behalf is submitted, a written, signed, and dated application for PSDP benefits which has been either completed or denied.
2. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.
3. "PSA" means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to carry out the administrative functions of the PSDP according to Laws 1997, Ch. 186 § 3.
4. "PSDP" means Premium Sharing Demonstration Project, which is a 3-year pilot program established according to A.R.S. § 36-2923.

R9-30-102. Scope of Services Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Chronic disease" means a non-acute condition that is not caused by alcohol, drug, or chemical addiction, and if not treated has a reasonable medical probability of causing a life-threatening situation or death. For the purposes of the PSDP, chronic disease includes only the following diagnoses as specified in Laws 1997, Ch. 186,

§ 3 & 4, as amended by Laws 1997, 2nd Special Session, Chapter 186 § 3 & 4:
a. Alpha-1-Antitrypsin Deficiency,
b. Amytrophic Lateral Sclerosis (Lou Gehrig's Disease),
c. Cardiomyopathy,
d. Chronic Liver Disease,
e. Chronic Pancreatitis,
f. Chronic Rheumatoid Arthritis,
g. Congenital Heart Disease,
h. Cystic Fibrosis,
i. Growth Hormone Deficiency,
j. Hematologic Cancer Patients,
k. Hemophilia,
l. History of any Solid Organ Transplant,
m. HIV/Acquired Immunodeficiency Syndrome,
n. Hodgkin's Disease,
o. Metastatic Cancer,
p. Multiple Sclerosis,
q. Muscular Dystrophy's,
r. Pulmonary Hypertension, and
s. Sickle Cell Disease.

2. "Chronically ill person" means a person who has been diagnosed with a chronic disease as defined in this Section and who has an annual gross household income at or below 400% of the FPL and who has been eligible for health care services according to A.R.S. § 11-297, for 12 consecutive months out of 15 consecutive months immediately preceding the date of application for the PSDP.
3. "Covered services" means the health and medical services specified in Article 2 of this Chapter.
4. "Pre-existing condition" means an illness or injury that is diagnosed or treated within a 6-month period preceding the effective date of coverage.

R9-30-103. Eligibility and Enrollment Related Definitions
Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Completed premium sharing application" means a PSDP application form, signed and dated by the head of household with all questions answered and accompanied by all documentation required to verify the information.
2. "Date of application" means the date a complete PSDP application is received in the PSA office.
3. "Eligible for AHCCCS benefits" means enrolled as a member of the Arizona Health Care Cost Containment System, beginning the 1st day of the month following the date a person has been determined eligible under A.R.S. 36-2901(4)(a),(b),(c),and (h).
4. "Enrollment" means the process by which an individual applies for coverage, is determined eligible, selects a PSDP contractor, and begins making premium payments to the PSA in order to receive services, if medically necessary, through a PSDP contractor.
5. "FPL" means the federal poverty level or otherwise known as the federal poverty guidelines published annually by the United States Department of Health and Human Services.
6. "Head of household" means the household member who assumes the responsibility for providing PSDP eligibility information for the household unit in accordance with Article 3 of this Chapter.
7. "Household income" means the total gross amount of all money received by all eligible or ineligible household members as cash, check, or their similar instrument, or as deposits into the household member's solely or jointly owned financial account.
8. "Household unit" means 1 or more individuals who reside together in a household and are considered in determining eligibility.
9. "Month of application" means the calendar month during which a completed PSDP application is received in the PSA office.
10. "Premium Share member" means any member of the household unit who is enrolled in the PSDP.
11. "Redetermination" means the periodic submission of a new, complete PSDP application by a current Premium Share member requesting continuation of PSDP coverage, and the review of that application and determination of ongoing eligibility and premium by the PSA.

R9-30-104. Reserved

R9-30-105. Reserved

R9-30-106. Grievance and Appeals Related Definitions
Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning. "Grievance" means a complaint initiated in accordance with Article 6 of this Chapter.

R9-30-107. Payment Responsibilities Related Definitions
Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Copayment" means a monetary amount a enrollee pays directly to a provider at the time covered services are rendered.
2. "Premium" means the total amount due monthly for the provision of covered services to enrollees.
3. "Premium share" means the portion of the premium, not to exceed 4% of the gross annual household income, an enrollee must pay monthly for the provision of covered services who is at or below 200% of FPL.
4. "Pre-payment" means submission of the enrollee's share of the premium due 30 days in advance of the effective date of coverage.

ARTICLE 2: SCOPE OF SERVICES

R9-30-201. General Requirements

A. In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:
1. Covered services provided to a Premium Share member shall be medically necessary and provided by, or under the direction of a primary care provider or dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a Premium Share member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral requirements;

2. Behavioral health services are limited to 30 days of inpatient and 30 outpatient visits annually as specified in Laws 1997, Ch. 186 § 3.
3. Services shall be rendered in accordance with state laws and regulations, the *Arizona Administrative Code* and PSA contractual requirements;
4. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;
5. PSDP services shall be limited to those services that are not covered for a Premium Share member who is covered by another funding source as specified in R9-30-301;
6. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
7. Personal care items are not covered and payment shall be denied;
8. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person who is in an institution for the treatment of mental disorders, unless provided according to this Article.

B. The PSA may require that providers be AHCCCS registered. Services may be provided by AHCCCS registered personnel or facilities that meet state requirements, and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization by the contractor is not obtained. Emergency services under A.R.S. § 36-2908 do not require prior authorization, however, the member must notify the contractor as required in R9-30-210(C).
1. For a Premium Share member, the contractor shall prior authorize services based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the Premium Share member's primary care provider or dentist.
2. Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.
3. In addition to the requirements of Article 7 of this Chapter, written documentation of diagnosis and treatment may be required for reimbursement for services that require prior authorization.

D. Covered services rendered to a Premium Share member shall be provided within the service area of the Premium Share member's primary contractor except when:
1. A primary care provider refers a Premium Share member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a Premium Share member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a Premium Share member or the Premium Share member's household;
4. A Premium Share member is placed in a nursing facility located out of the contractor's service area;
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.

E. When a Premium Share member is traveling or temporarily residing out of the service area of the Premium Share member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. The Director shall determine the circumstances under which a Premium Share member may receive services, other than emergency services, from service providers outside the Premium Share member's county of residence or outside the state. Criteria considered by the Director in making this determination shall include availability, accessibility of appropriate care, and cost effectiveness.

H. If a Premium Share member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time the contractor shall also provide all other medically necessary covered services for the Premium Share member during that time.

I. The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any noncovered service to a Premium Share member and shall not be included in development or negotiation of capitation.

J. In accordance with A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors, modify the list of services for all Premium Share members.

K. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay a copayment in full at time the service is rendered as specified on Laws 1997, Ch. 186 § 3.

L. A pregnancy shall not be considered a pre-existing condition for the purposes of refusing services as specified in Laws 1997, Ch. 186 § 3.

R9-30-202. Reserved

R9-30-203. Reserved

R9-30-204 Inpatient General Hospital Services

A. The contractor shall provide inpatient general hospital accommodations and appropriate staffing, supplies, equipment, and services for:
1. Maternity care;
2. Neonatal intensive care (NICU);
3. Intensive care (ICU);
4. Surgery;
5. Nursery;
6. Routine care; and
7. Behavioral health (psychiatric) care.
   a. A Premium Share member is eligible for a maximum of 30 days of impatient behavioral health services annually as specified in Laws 1997, Ch.186 § 3.
   b. For the purpose of this Section, the PSDP contract year shall be October 1 through September 30.

B. The contractor shall provide ancillary services as specified by the Director and included in contract:
1. Labor, delivery, recovery rooms, and birthing centers;
2. Surgery and recovery rooms;
3. Laboratory services;
4. Radiological and medical imaging services;
5. Anesthesiology services;
6. Rehabilitation services;
7. Pharmaceutical services and prescribed drugs;
8. Respiratory therapy;
9. Blood and blood derivatives;

10. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
11. Maternity services; and
12. Nursery and related services.

R9-30-205. Primary Care Provider Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a Premium Share member when rendered within the provider's scope of practice under A.R.S. Title 32. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
   1. Periodic health examinations and assessments;
   2. Evaluations and diagnostic workups;
   3. Medically necessary treatment;
   4. Prescriptions for medications and medically necessary supplies and equipment;
   5. Referrals to specialists or other health care professionals when medically necessary;
   6. Patient education;
   7. Home visits when determined medically necessary;
   8. Covered immunizations; and
   9. Covered preventive health services.

B. The following limitations and exclusions apply to primary care provider services:
   1. Specialty care and other services provided to a Premium Share member upon referral from a primary care provider or to a Premium Share member upon referral from the primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor;
   2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the Premium Share member's contractor, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
      a. Qualification for insurance;
      b. Pre-employment physical evaluation;
      c. Qualification for sports or physical exercise activities;
      d. Pilot's examination (FAA);
      e. Disability certification for establishing any kind of periodic payments;
      f. Evaluation for establishing 3rd-party liabilities; or
      g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
   3. Orthognathic surgery shall be covered only for a Premium Share member who is less than 21 years of age;
   4. The following services shall be excluded from PSDP coverage:
      a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
      b. Abortion counseling services;
      c. Abortions, unless authorized under state law, as specified in A.R.S. § 36-2903.01;
      d. Services or items furnished solely for cosmetic purposes;
      e. Hysterectomies unless determined to be medically necessary;
      f. Elective surgeries with the exception of voluntary sterilization procedures; and
      g. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-30-206. Organ and Tissue Transplantation Services

A. A Premium Share member who has a chronic illness as specified in Laws 1997, Ch.186 § 3 and 4, as amended by Laws 1997, Second Special Session, Chapter 186, § 3 and 4, is eligible for the following organ and tissue transplantation services as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the Premium Share member's contractor for a Premium Share member:
   1. Kidney transplantation;
   2. Cornea transplantation;
   3. Heart transplantation;
   4. Liver transplantation;
   5. Autologous and allogeneic bone marrow transplantation;
   6. Lung transplantation;
   7. Heart-lung transplantation;
   8. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
   9. Immunosuppressant medications, chemotherapy, and other related services.

B. Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

R9-30-207. Dental Services

A. Emergency dental care, which encompasses the following services, shall be covered:
   1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
   2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
   3. Initial treatment for acute infection;
   4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
   5. Preoperative procedures; and
   6. Anesthesia appropriate for optimal patient management.

B. Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

R9-30-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services shall be covered services if:
   1. Prescribed for a Premium Share member by the primary care provider or the dentist, unless referral is waived by the contractor;
   2. Provided in a hospital, clinic, physician office or other health care facility by a licensed health care provider; and
   3. Provided by a provider that meets all applicable state license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

R9-30-209. Pharmaceutical Services

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a Premium Share member's residence.

C. Pharmaceutical services shall be covered if prescribed for a Premium Share member by the Premium Share member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider or dentist unless referral is waived by the contractor and upon authorization by the contractor or its designee's formulary.

D. The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a primary care provider or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The Premium Share member will be out of the contractor's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate, alternative over-the-counter medication is available and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill is dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a Premium Share member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services

A. Emergency medical services and emergency behavioral health services may be provided to a Premium Share member by licensed providers.

B. Emergency medical and behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area.

C. The Premium Share member shall notify the contractor within 48 hours after the initiation of treatment. If a Premium Share member is incapacitated, the provider is responsible for notifying the contractor within 48 hours after the initiation of treatment. Failure of the Premium Share member or provider to notify the contractor as required shall result in denial of payment.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

E. Emergency services do not require prior authorization.

1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a Premium Share member shall notify the Premium Share member's contractor within 12 hours of the time the Premium Share member presents for services;
2. If a Premium Share member's medical condition is determined not to be an emergency medical condition as defined in A.A.C. R9-22-101, the provider shall notify the Premium Share member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the Premium Share member's nonemergency condition. Failure by the provider to provide timely notice or to comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

R9-30-211. Transportation Services

A. Emergency ambulance services.

1. Emergency ambulance transportation shall be a covered service for a Premium Share member. Payment shall be limited to the cost of transporting the Premium Share member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the Premium Share member's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed according to the terms and conditions that the PSA specified in the contractor's contract, if the medical condition at the time of transport justified a medically necessary or emergency ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the Premium Share member at the time of transport.
4. A ground or air ambulance provider furnishing transportation in response to a 911 call or other emergency response system shall notify the Premium Share member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.

B. Medically necessary nonemergency transportation. A Premium Share member is responsible for the full cost of any nonemergency transportation as specified in Laws 1997, Ch.186 § 3, except as specified in subsection (A) of this Section.

R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:

1. Prescribed for a Premium Share member by the Premium Share member's primary care provider, unless referral is waived by the contractor; or
2. Provided in compliance with requirements of this Chapter; and
3. Provided in compliance with the contractor's requirements.

B. Medical supplies include consumable items covered under Medicare that are provided to a Premium Share member and that are not reusable.
C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a Premium Share member.
D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a Premium Share member.
E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction.
F. The following limitations apply:
1. If medical equipment can not be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the Premium Share member's primary care provider or authorized prescriber, or prior authorized by the PSA for Premium Share members, and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the Premium Share member's contractor, without prior written notification of the change or addition.
4. Rental fees shall terminate:
a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the Premium Share member no longer needs the medical equipment;
b. When the Premium Share member is no longer eligible for PSDP services; or
c. When the Premium Share member is no longer enrolled with a contractor, with the exception of transition of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for a Premium Share member who is 21 years of age and older, unless authorized under subsection (E).
G. Liability and ownership.
1. Purchased durable medical equipment provided by a contractor for a Premium Share member, but which is no longer needed, may be disposed of in accordance with each contractor's policy.
2. The contractor shall retain title to purchased durable medical equipment supplied to a Premium Share member who becomes ineligible or no longer requires its use.
3. If customized durable medical equipment is purchased by the contractor for a Premium Sharing member by the contractor, the equipment will remain with the person during times of transition, or upon loss of eligibility.
a. For purposes of this section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a Premium Share member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
b. Customized equipment obtained fraudulently by a Premium Share member shall be returned for disposal to the Premium Share member's contractor if the customized equipment was purchased for a Premium Share member.

R9-30-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
A. The following EPSDT services shall be covered for a Premium Share member less than 21 years of age:
1. Screening services, including:
a. Comprehensive health and developmental history;
b. Comprehensive unclothed physical examination;
c. Appropriate immunizations according to age and health history;
d. Laboratory tests; and
e. Health education, including anticipatory guidance;
2. Vision services, including:
a. Diagnosis and treatment for defects in vision;
b. Eye examinations for the provision of prescriptive lenses; and
c. Provision of prescriptive lenses;
3. Hearing services, including:
a. Diagnosis and treatment for defects in hearing;
b. Testing to determine hearing impairment; and
c. Provision of hearing aids;
4. Dental services including:
a. Emergency dental services as specified in R9-30-207;
b. Preventive services including screening, diagnosis, and treatment of dental disease; and
c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery; and
6. Behavioral health services specified in this Chapter;
B. All providers of EPSDT services shall meet the following standards:
1. Provide services by, or under the direction of, the Premium Share member's primary care provider or dentist;
2. Perform tests and examinations in accordance with the PSA Periodicity Schedule;
a. Refer a Premium Share member as necessary for dental diagnosis and treatment, and necessary specialty care; or
b. Refer a Premium Share member as necessary for behavioral health evaluation and treatment services.

R9-30-214. Reserved

R9-30-215. Other Medical Professional Services
A. The following medical professional services provided to a Premium Share member by a contractor, shall be covered services when provided in an inpatient, outpatient, or office setting within limitations specified below:
1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:

a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
b. Sterilization; and
c. Natural family planning education or referral;

3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife service for prenatal care and home births in low risk pregnancies;
5. Podiatry services when ordered by a Premium Share member's primary care provider;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services;
12. Chemotherapy; and
13. A Premium Share member is eligible for a maximum 30 days of inpatient and of 30 outpatient behavioral health visits annually as specified in Laws 1997, Ch 186 § 3.

B. The following shall be excluded as PSDP covered services:
1. Occupational and speech therapies provided on an outpatient basis for a Premium Share member who is 21 years of age or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

R9-30-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a Premium Share member is that, if nursing facility services are not provided, hospitalization of the individual would result.
B. Except as otherwise provided in A.A.C. Title 9, Chapter 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
a. Administration of medication;
b. Tube feedings;
c. Personal care services (assistance with bathing and grooming);
d. Routine testing of vital signs; and
e. Maintenance of catheters;
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
b. Bathing and grooming supplies;
c. Identification devices;
d. Skin lotions;
e. Medication cups;
f. Alcohol wipes, cotton balls, and cotton rolls;
g. Rubber gloves (non sterile);
h. Laxatives;
i. Beds and accessories;
j. Thermometers;
k. Ice bags;
l. Rubber sheeting;
m. Passive restraints;
n. Glycerin swabs;
o. Facial tissue;
p. Enemas;
q. Heating pads;
r. Diapers; and
s. Alcoholic beverages;
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and durable medical equipment.

C. Each admission shall be prior authorized by the contractor for a Premium Share member.

R9-30-217. Behavioral Health Services

A. General Requirements. A Premium Share member with a behavioral or substance abuse disorder shall be eligible for behavioral health services with the limitations of 30 days of inpatient and 30 outpatient visits annually as specified in Laws 1997, Ch. 186 § 3.
B. Service Delivery System and Referral. A contractor shall be responsible for the provision of medically necessary behavioral health services to a Premium Share member.
C. Covered Behavioral Health Services for a Premium Share member:
1. The following requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations.
a. The service shall be medically necessary, cost effective and PSDP reimbursable;
b. The service shall be provided by qualified service providers as specified in contract;
c. A service provider, as applicable, shall contract with a contractor;
d. A services shall be authorized, as applicable, by the contractor; and
e. Services shall be provided in appropriate residential settings which meet state licensing standards;
2. The following behavioral health services shall be covered, subject to the limitations and exclusions in the contract:
a. Inpatient services;
b. Professional services;
c. Rehabilitation services;
d. Evaluation and case management services;
e. Behavioral health-related services;
f. Emergency transportation services;
g. Qualifications and standards of participation for service providers; and
h. Utilization control.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

A. Expenditure limit. Enrollment in the PSDP is limited to funding as specified in Laws 1997, Ch. 186 § 3 and 4, as amended

by Laws 1997, 2nd Special Session Ch. 186 § 3 and 4. The PSA will accept enrollees subject to the availability of funds. Applicants will be placed on a waiting list after it is estimated that 80% of the annual expenditures will be reached. When funding becomes available, individuals on the waiting list will be contacted and asked to submit a new application if the original application is more than 60 days old. Spaces will be filled as the complete applications are received.

B. Participation. Subject to the expenditure limitation specified in Section (A), a person who meets all eligibility requirements and who is not chronically ill, may be approved and shall:
   1. Pay a premium;
   2. Pay a copayment; and
   3. Have income at or below 200% FPL.

C. Health history questionnaire. An applicant who has been determined eligible for the PSDP shall receive a health history questionnaire which must be completed by each eligible household member and returned with the 1st premium payment for each household member to be enrolled in the PSDP.

D. Chronically ill cap and waiting list.
   1. The PSA shall limit the total number of all chronically ill enrollees in the PSDP to 200 persons as specified in Laws 1997, Ch. 186 § 3 and 4 as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3 and 4. When the PSDP has reached this limitation, and subject to the expenditure limit as specified in Section (A), applicants will be placed on a waiting list. When funding becomes available, individuals on the waiting list will be contacted, and asked to submit a new application if the application is more than 60 days old. Spaces will be filled as the complete applications are received.
   2. The chronic illness cap applies to all chronically ill persons whose gross household income does not exceed 400% of FPL.

R9-30-302. Submission of Application

A. Applications. The PSA will not accept an application until the application is complete. The PSA will return incomplete applications to the applicant. For an application to be complete:
   1. All questions must be answered; and
   2. All necessary verification shall be attached to the application.

B. Returned applications. The PSA shall return incomplete applications only twice. The returned applications must be received by the PSA within 60 days of the initial application or a new application shall be required.

R9-30-303. Eligibility and Ineligibility Criteria

A. PSDP general requirements for eligibility and ineligibility.
   1. Citizenship status. To participate in the PSDP, an applicant shall meet 1 of the following citizenship requirements:
      a. Be a United States citizen as specified in A.R.S § 36-2903.01 and Laws 1997, Ch. 186 § 3; or
      b. Be a qualified alien as specified in A.R.S. § 36-2903.01;
   2. Residency. An applicant shall be a resident of Arizona as specified in Laws 1997, Ch. 186 § 3, and a resident of 1 of the counties served by the pilot which include:
      a. Cochise county;
      b. Maricopa county;
      c. Pima county; or
      d. Pinal county;
   3. Income.
      a. The PSA will annualize gross household income received by all household members during the 3 calendar months immediately before the month of application; and
      b. The PSA will count gross income from employment, self-employment, rental, public assistance benefits, other earned and unearned income as specified in the PSDP policy manual.
   4. Deductions from income. The PSA allows deductions from the gross income only for:
      a. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered; or
      b. Payments made to cover the costs of doing business and payments made to cover the costs of producing income from rental property as specified in the PSDP policy manual;
   5. Income disregards. The PSA does not disregard other income for PSDP eligibility;
   6. Income limits. The annualized gross household income, less deductions shall not exceed 200% of the FPL as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, Second Special Session, Ch. 186 § 3 or 400% FPL for a chronically ill person;
   7. Income verification. Verification for all sources of income shall be provided for all household members for the 3 calendar months before the month of application.
      a. The PSA shall review provided verification of the gross amount of income and the date the income was paid to the household member as specified in subsection (A)(3); and
      b. When the applicant fails to provide verification of income, the application is incomplete and will not be accepted;
   8. Household composition. The PSA determines eligibility by household unit. Members of the same household must be included on the application. The following individuals, when living together, are members of the same household:
      a. Head of household;
      b. A legal spouse of the head of household. This includes spouses who are temporarily away from the home due to employment or who are seeking employment within Arizona;
      c. A common-law spouse of the head of household. A common-law spouse is a legal spouse when the applicant and spouse have lived together in, and met the requirements for, common-law marriage in a state that recognizes these marriages;
      d. Other parent. The other parent or guardian of a dependent child when that person is not the spouse of the head of household; and
      e. A dependent child. A dependent child who is unmarried, has not reached age 19, and is a natural child, adopted child, a step-child of the head of household or spouse or both, or the natural child of another dependent child who is a household member, a child supported by the head of household or spouse or both as a result of a court order, or a child for whom the head of household or spouse is a legal guardian unless that child's adult parent is sharing the residence;
   9. Cooperation. An applicant shall cooperate in providing the necessary information to verify eligibility;

10. Fraud. An applicant who has been convicted of fraud or abuse in the following programs in any state is not eligible to participate:
    a. The PSDP;
    b. Temporary Assistance to Needy Families (TANF);
    c. Aid to Families with Dependent Children (AFDC);
    d. General Assistance (GA);
    e. Foodstamps;
    f. Medicaid; or
    g. State or county sponsored medical assistance programs; and
11. Other health care coverage. An applicant who is currently insured, or who has had health care coverage other than AHCCCS in the 6 months prior to application for the PSDP, is not eligible for coverage under the PSDP, as specified in Laws 1997, Ch. 186 § 3.
    a. Veterans Administration (VA) coverage. An applicant who has VA coverage for a medical condition is not eligible for coverage of only that medical condition or medical conditions under the PSDP.
    b. Medicare benefits. An applicant who has Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSDP.
    c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits under Title 11, Chapter 2, Arizona Revised Statutes, or Title 36, Chapter 29, Arizona Revised Statutes is not eligible for the PSDP. The PSA may screen an application to determine if an applicant is eligible for any of these programs. An applicant shall declare whether the applicant has been determined ineligible for these programs. An applicant is encouraged to apply for Medicaid benefits prior to approval for the PSDP.
    d. Exceptions to AHCCCS benefits. Women who are eligible for assistance under the Sixth Omnibus Budge Reconciliation Act (SOBRA) may apply for the PSDP as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, Second Special Session, Ch. 186 § 3.
    e. State Children's Health Insurance Program (SCHIP). A child who is eligible for SCHIP is eligible for participation in the PSDP for a limited time as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, Second Special Session, Ch. 186 § 3.
    f. Payor of last resort. PSA contractor shall not be the primary payor for any claim involving workers compensation, automobile insurance or homeowner's insurance.

B. Requirements for a chronically ill person.
1. General Requirements. A chronically ill applicant shall meet the requirements in subsection (A)(1) through subsection (A)(11).
2. Other health care coverage. The restriction on an applicant who has had health care coverage as specified in subsection (A)(11) does not apply to a chronically ill person.
3. Chronic illness coverage. The following limitations shall apply for any applicant who meets the requirements for coverage as a chronically ill person as specified in R9-30-102.
    a. Limited enrollment. There is a 200-space limit for the chronically ill. An applicant shall be placed on a waiting list once the spaces are filled or expenditure limits are reached as specified in subsection (A)(1) and Laws 1997, Ch. 186 § 3 and 4, as amended by Laws 1997, 2nd Special Session, Ch. 186 § and 4.
    b. Continuous AHCCCS coverage. A chronically ill applicant whose gross household income exceeds 200% of the FPL but does not exceed 400% of the FPL shall have been receiving services under A.R.S § 11-297 for at least 12 of the 15 months preceding the month of application.
    c. Medical Verification. An applicant who is chronically ill shall submit a written statement from a physician indicating that the applicant's illness meets the definition of chronic disease as specified in R9-30-102.
    d. Premium. A chronically ill applicant and each household member whose gross household income is at or below 400% of the FPL but greater than 200% of the FPL shall pay the full premium for each applicant and each household member as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.
    e. Failure to claim chronic disease. Chronically ill applicants who fail to state that they have 1 of the chronic diseases as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, Ch. 186 § 3, and R9-30-102 at the time of application may be denied or referred to the PSA for potential fraud.

R9-30-304. Enrollment

A Premium Share member shall pay the premiums and copayments as specified in Laws 1997, Ch. 186 § 3, for continued enrollment in the PSDP.

A. Health Plan choice. An applicant shall select a health plan at the time of application. All eligible household members will be enrolled with the same plan. A Premium Share member shall have freedom of choice of a PSDP contractor when there is 1 or more contractors in the service area.
B. Open enrollment. Each eligible household unit will have the opportunity to switch to a new health plan 12 months after the household unit's initial enrollment and each year thereafter.

R9-30-305. Disenrollment

A Premium Share member will be disenrolled for the PSDP as specified in Laws 1997, Ch. 186 § 3.

1. Reasons for disenrollment. A Premium Share member will be disenrolled from the PSDP when eligibility criteria, as specified in Laws 1997, Ch. 186 § 3, are no longer met:
    a. Non-payment of premiums and copayments;
    b. Moving out of the participating counties served by the PSDP;
    c. Provision of false or fraudulent information on the Premium Sharing application;
    d. Two submissions of a returned check during enrollment;
    e. No longer meeting the eligibility requirements; or
    f. The PSDP expires.
2. Exception. A Premium Share member who is confined to a hospital on the effective date of disenrollment shall continue to receive coverage until a determination by the contractor's Medical Director or designee, that care in the hospital is no longer medically necessary for the condition for which the member was admitted.

3. Grievance and appeal process. A Premium Share member has a right to file a grievance or appeal as specified in R9-30-601 et seq.
4. PSDP participation. A Premium Share member who has been disenrolled from the PSDP will not be allowed to re-enroll for a period of 12 consecutive months. The 12-month period begins with the date of disenrollment as specified in Laws 1997, Ch. 186 § 3.
5. Health Insurance Portability and Accountability Act (HIPAA) of 1996. A Premium Share member who has been disenrolled shall be allowed to use enrollment in the PSDP as creditable coverage as defined in P.L. 104-191 as specified in Laws 1997, Ch. 186 § 3, as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.

R9-30-306. Redetermination

A. The PSA will conduct a redetermination of eligibility on each Premium Sharing household unit once every 6 months as specified in Laws 1997, Ch. 186 § 3, unless the household unit becomes ineligible prior to this time.
B. The 6-month period will begin with the month the applicant is enrolled.
C. The PSA will conduct a redetermination on a Premium Share household unit when a Premium Share member moves from 1 PSDP county to another participating PSDP county. A Premium Share member hall remain enrolled in the PSDP if they meet the eligibility criteria The Premium Share member shall have a redetermination completed 6 months from the new date of eligibility.

ARTICLE 4. CONTRACTS

R9-30-401. General Provisions

A. Requirements. The PSA and qualified providers of health care who have contracts to provide services under AHCCCS shall conform to the requirements in this Article and Laws 1997, Ch. 186 §§ 3 and 4, as amended by Laws 1997, 2nd Special Session, Ch. 186 §§ 3 and 4. A contractor that has contracts and subcontracts entered into in accordance with this Article shall have records on file.
B. Contract. A contract may be canceled or rejected in whole or in part, as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.
C. Damages or Claims. Offerors shall have no right to damages or basis for any claims against the state, it's employees, or agents, arising out of any action by the PSA according to the provisions of subsection (B) of this Section.

R9-30-402. Reserved

R9-30-403. PSA's Contracts with Contractors

A. As specified in Laws 1997, Ch. 186 § 3, the AHCCCS Administration is authorized to contract with contractors that contract with the AHCCCS Administration according to A.R.S. § 36-2912.
B. If the Director determines there is insufficient coverage in a county participating in the PSDP, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSDP, as specified in Laws 1997, Ch. 186 § 3.
C. Each contract between the PSA and a contractor shall be in writing and contain at least the following information:
   1. The method and amount of compensation or other consideration to be received by the contractor;
   2. The name and address of the contractor;
   3. The population to be covered by the contract;
   4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;
   5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination;
   6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract;
   7. A description of a Premium Share member, medical and cost record-keeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, 5 years after the date of final disposition or resolution of the exception;
   8. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the PSA during normal business hours at the place of business of the person or organization maintaining the records;
   9. A provision that the contractor safeguard information;
   10. A provision that the contractor arrange for the collection of any required copayment by the provider;
   11. A provision that the contractor will not bill or attempt to collect from a Premium Share member for any covered service except as may be authorized by statute or rules in this Chapter;
   12. A provision that the contract will not be assigned or transferred without the prior approval of the Director;
   13. Procedures and criteria for terminating the contract;
   14. Procedures for terminating enrollment and choice of health professional;
   15. A provision that a contractor provide for an internal grievance procedure that:
      a. Is approved in writing by the PSA;
      b. Provides for prompt resolution; and
      c. Ensures the participation of individuals with authority to require corrective action;
   16. A provision that the contractor maintain an internal quality management system;
   17. A provision that the contractor submit marketing plans, procedures, and materials to the PSA for approval before implementation;
   18. A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge;
   19. A provision that the contractor is responsible for all:
      a. Tax obligations;
      b. Worker's Compensation Insurance; and
      c. All other applicable insurance coverage, for itself and its employees, and that the PSA has no responsibility or liability for any of the taxes or insurance coverage; and
   20. A provision that the contractor agrees to comply with all applicable statutes and rules.

R9-30-404. Subcontracts

A. Approval. A contractor entering into a subcontract to provide services to a Premium Share member must meet the require-

ments specified in the contract. Any amendment to a subcontract shall be subject to review and approval by the Director.

B. Subcontracts. Each subcontract shall be in writing and include:
1. The subcontract that is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor;
2. Provision to notify the PSA in the event the subcontract is amended or terminated;
3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the PSA;
4. Provision to hold harmless the state, the Director, the PSA, and a Premium Share member in the event the contractor cannot or will not pay for covered services performed by the subcontractor;
5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the Director for a violation of these rules;
6. Provision to hold harmless and indemnify the state, the Director, the PSA, or a Premium Share member, through the negligence of the subcontractor;
7. Provision that a Premium Share member is not to be held liable for payment to a provider in the event of contractor's bankruptcy;
8. The method and amount of compensation or other consideration to be received by the subcontractor;
9. The amount, duration, and scope of medical services to be provided by the subcontractor, for which compensation will be paid; and
10. The requirements contained in R9-30-403(C)(1) through (C)(13) and (C)(18) through (C)(20) substitute the term "subcontractor" wherever the term "contractor" is used.

R9-30-405. Contract Records

All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 41-2550.

R9-30-406. Merger; Reorganization; Change; and Contract Amendment

A. Merger; Reorganization; or Change. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a contractor.

B. Amendment. The Director shall prior approve any proposed merger, reorganization, or change in ownership or a subcontractor that is related to or affiliated with the contractor and shall require a contract amendment. To be effective, contract amendments shall be in writing and executed by the Director.

R9-30-407. Suspension; Denial; Modification; or Termination of Contract

A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause as specified in contract.

B. Modification and termination of the contract without cause. The AHCCCS Administration and contractor by mutual consent may modify or terminate the contract at any time without cause. Additionally, the AHCCCS Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.

C. Notification.
1. The Director shall provide the contractor written notice of:
a. Intent to suspend;
b. Deny;
c. Fail to renew; or
d. Terminate a contract or related subcontract.
2. The PSA shall provide a notice to affected principals, a Premium Share member and other interested parties, and shall include:
a. The effective date; and
b. Reason for the action.

D. Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.

R9-30-408. Contract Compliance Sanction Alternative

The Director may impose a sanction to a contractor that violates any provision of the rules as specified in contract.

R9-30-409. Contract or Protest; Appeal

The contractor shall file a grievance as specified in A.A.C. R9-22-804.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-501. Reserved

R9-30-502. Availability and Accessibility of Services

A. A contractor shall provide adequate numbers of available and accessible:
1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.

B. A contractor shall minimally provide the following:
1. The requirements of the number of primary care providers to the number of adults and children, may be specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to a member in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;
3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to a member who needs information in an emergency, and to a provider who needs verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
a. Premium Share member's name;
b. Address and telephone number;
c. Date and time of call;
d. Nature of complaint or problem; and
e. Instructions given to a Premium Share member; and
5. A written procedure for communicating emergency services information to a Premium Share member's primary care provider, and other appropriate organizational units.

C. A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under

the primary care provider's guidance and direction as specified in contract. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contractor, within the service area of the contractor.

R9-30-503. Reserved

R9-30-504. Marketing

The PSA shall require a contractor to develop a marketing plan as specified in Laws 1997, Ch. 186, § 3 and as specified in contract.

R9-30-505. Reserved

R9-30-506. Reserved

R9-30-507. Member Record

A contractor shall maintain a Premium Share member service record that contains at least the following for each Premium Sharing member:

1. Encounter data, if required by PSA;
2. Grievances and appeals;
3. Any informal complaints; and
4. Service information.

R9-30-508. Reserved

R9-30-509. Transition and Coordination of Member Care

The PSA shall coordinate and implement disenrollment and reenrollment procedures when a Premium Share member's change of residency requires a change in contractor as specified in contract.

R9-30-510. Transfer of a Member

A contractor shall implement procedures to allow a Premium Share member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

1. Change in the Premium Share member's health, requiring a different medical focus;
2. Change in the Premium Share member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the Premium Share member and the primary care provider, resulting in deterioration of the primary care provider member relationship.

R9-30-511. Fraud and Abuse

A contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse as specified in R9-30-303.

R9-30-512. Release of Safeguarded Information by the PSA and Contractor

A. The PSA, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant, or a Premium Share member, which includes the following:
   1. Name and address;
   2. Social Security number;
   3. Social and economic conditions or circumstances;
   4. Agency evaluation of personal information;
   5. Medical data and services, including diagnosis and history of disease or disability;
   6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
   7. Information system tapes from the Arizona Department of Economic Security, if required;

B. The restriction upon disclosure of information does not apply to:
   1. Summary data;
   2. Statistics;
   3. Utilization data; and
   4. Other information that does not identify a Premium Share member.

C. The PSA, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning a Premium Share member only under the conditions specified in subsection (D), (E), and (F) and only to:
   1. The person concerned;
   2. Individuals authorized by the person concerned; and
   3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released to only:
   1. An applicant;
   2. A Premium Share member; or
   3. A dependent child, with written permission of a parent, custodial relative, or designated representative, if:
      a. If a PSA employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
      b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

E. An eligibility case record, medical record, and any other PSDP-related confidential and safeguarded information regarding Premium Share member or applicant, shall be released to individuals authorized by the Premium Share member or applicant, only under the following conditions:
   1. Authorization for release of information is obtained from the Premium Share member, applicant, or designated representative;
   2. Authorization used for release is a written document, separate from any other document, that specifies the following information:-
      a. Information or records, in whole or in part, which are authorized for release;
      b. To whom release is authorized;
      c. The period of time for which the authorization is valid, if limited; and
      d. A dated signature of the adult and mentally competent Premium Share member, applicant, or designated representative. If a Premium Share member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If a Premium Share member or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509; or
   3. If an appeal or grievance is filed, the Premium Share member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:
   1. Official purposes directly related to the administration of the PSDP are:
      a. Establishing eligibility and post-eligibility treatment of income, as applicable;
      b. Providing services for a Premium Share member;

c. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the PSDP program; and
d. Performing evaluations and analyses of PSDP operations;

2. For official purposes related to the administration of the PSDP program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, or Premium Share member:
a. Employees of the PSA;
b. Employees of the AHCCCS Administration;
c. Employees of the U.S. Social Security Administration;
d. Employees of the Arizona Department of Economic Security;
e. Employees of the Arizona Department of Health Services;
f. Employees of the U.S. Department of Health and Human Services;
g. Employees of contractors, program contractors, providers, and subcontractors; and
h. Employees of the Arizona Attorney General's Office, and the County Attorney, if applicable.

3. Law enforcement officials:
a. Information may be released to law enforcement officials without the applicant's or Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the PSDP program.
b. The PSA and contractors shall release safeguarded information contained in an applicant's or Premium Share member's medical record to law enforcement officials without the Premium Share member's consent only if the applicant or Premium Share member is suspected of fraud or abuse against the PSDP program.
c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the PSA, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The PSA may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or Premium Share member.
5. Providers shall furnish requested records to the PSA and its contractors at no charge.

G. The holder of a medical record of a former applicant or Premium Share member shall obtain written consent from the former applicant, or Premium Share member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a Premium Share member before transmitting the Premium Share member's medical records to a physician who:
1. Provides a service to the Premium Share member under subcontract with the contractor;
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and
3. Provides a service under the contract.

R9-30-513. Discrimination Prohibition

A contractor, provider, and nonprovider shall not discriminate against a Premium Share member as specified in federal and state law.

R9-30-514. Equal Opportunity

A contractor shall meet the requirements in Title VI of the U.S. Civil Rights Act of 1964, 42 USC, Section 5000e. A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:
1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the PSA to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

R9-30-515. Reserved

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R9-30-517. Reserved

R9-30-518. Information to an Enrolled Member

A. Each contractor shall produce and distribute a printed member handbook to each household unit by the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the contractor shall only be liable for services authorized by a Premium Share member's primary care provider or the contractor;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the Premium Share member, and a description of the selection process, including a statement that informs the Premium Share member they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the contractor's service area;
6. The causes for which a member may lose coverage;
7. A description of the grievance procedures;
8. Copayment schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the contractor; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each contractor shall prepare and distribute to a Premium Share member, a printed member handbook insert describing any changes that the contractor proposes to make in services provided within the contractor's service area. The insert shall be distributed to all household units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

R9-30-519. Reserved

R9-30-520. Financial Statements, Periodic Reports and Information

Upon request by the PSA, a contractor shall furnish to the PSA financial statements, periodic reports and information from its records relating to contract performance as specified in contract.

R9-30-521. Program Compliance Audits

The PSA may conduct a program compliance audit of each contractor on a periodic basis as specified in contract.

R9-30-522. Quality Management/Utilization Management (QM/UM) Requirements

A PSA contractor shall comply with the quality management and utilization review requirements as specified in contract.

R9-30-523. Financial Resources

A. A contractor or offeror shall demonstrate upon request to the PSA that it has:
   1. Adequate financial reserves;
   2. Administrative abilities; and
   3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2912, the Director requires that contract provisions include, but not be limited to:
   1. Maintenance of deposits;
   2. Performance bonds unless waived as specified in A.R.S. § 36-2912;
   3. Financial reserves; or
   4. Other financial security, unless waived as specified in A.R.S § 36-2912.

R9-30-524. Continuity of Care

A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
   1. Referring a Premium Share member who needs specialty health care services;
   2. Monitoring a Premium Share member with chronic medical conditions;
   3. Providing hospital discharge planning and coordination including post-discharge care; and
   4. Monitoring operation of the system through professional review activities.

ARTICLE 6. GRIEVANCES AND APPEALS

R9-30-601. General Provisions for all Grievances and Appeals

A. General Requirements. All grievances and appeals regarding Premium Sharing shall be filed and processed in accordance with A.A.C. R9-22-801. All references in that rule to AHCCCS also shall apply to PSA, and all references to health plans and system providers shall also apply to Premium Sharing Plans. In eligibility appeals, PSA is the respondent.

B. The AHCCCS Chief Hearing Officer or designee may deny a request for hearing if the sole issue presented is a state law requiring an automatic change adversely affecting some or all applicants or a Premium Share member.

R9-30-602. Eligibility Appeals and Hearing Requests for an Applicant and a Premium Share Member

A. Adverse eligibility action. An applicant and a Premium Share member may appeal and request a hearing concerning any of the following adverse eligibility actions:
   1. Denial of eligibility;
   2. Discontinuance of eligibility;
   3. Determination of premium amount; or
   4. Chronic illness determination.

B. Notice of an adverse eligibility action. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the notice of action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.
   1. The applicant or a Premium Share member may appeal and request a hearing regarding any adverse eligibility action by completing and submitting the premium sharing request for hearing form or by submitting a written request containing the following information:
      a. The case name;
      b. The adverse eligibility action being appealed; and
      c. The reason for appeal.
   2. The Request for Hearing shall be filed not later than 15 days after the date of the notice of adverse action by mailing or delivering it to the PSA, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. PSA responsibilities.
   1. The PSA shall maintain a register which documents the dates on which requests for hearings are submitted.
   2. If requested, the PSA shall assist the applicant or a Premium Share member in the completion of the request for hearing form.
   3. The pre-hearing summary shall be completed by the PSA and shall summarize the facts and factual basis for the adverse eligibility action.
   4. The PSA shall send to the Office of Grievance and Appeals, the Pre-hearing summary, a copy of the case file, documents pertinent to the adverse action, and the request for hearing, which must be received by the, Office of Grievance and Appeals, not later than 10 days from the date of the receipt of the request. If the request is submitted directly to the Office of Grievance and Appeals, the PSA shall send the materials to the Office of Grievance and Appeals, not later than 10 days from the date of a request for the materials.

E. PSDP coverage during the appeal process.
   1. A Premium Share member appealing a discontinuance. A discontinuance is a termination of Premium Sharing benefits. If a Premium Share member requests a timely hearing, the Premium Share member shall receive continued Premium Sharing benefits until an adverse decision on appeal is rendered only if the Premium Sharing member pays for 3 months worth of premiums, by cashier's check, personal check, or money order, within 15 days of the mailing of the notice of discontinuance.
   2. An applicant appealing a denial of Premium Sharing coverage. A denial is an adverse eligibility decision which finds the applicant ineligible for PSDP benefits. In the event that a timely request for hearing is filed, and the denial is overturned, the effective date of PSDP coverage shall be established by the Director in accordance with applicable law.
   3. A Premium Share member whose benefits have been continued shall be financially liable for all PSDP benefits received during a period of ineligibility, if a discontinuance decision is upheld by the Director.

R9-30-603. Grievances

General Requirements. All grievances regarding PSDP shall be filed and processed in accordance with A.A.C. R9-22-804. All ref-

erences in that rule to AHCCCS also shall apply to the PSA, and all references to contractors shall also apply to contractors.

ARTICLE 7: PAYMENT RESPONSIBILITIES

R9-30-701. A Premium Share Member's Payment Responsibilities

A. Premium payment requirement. A Premium Share member shall pay the required premium payment established by the PSA as specified in Laws 1997, Ch. 186 § 3 as amended by Laws 1997, 2nd Special Session, Ch. 186 § 3.

B. Premium payment based on household income under 200% of FPL. A Premium Share member whose gross household income does not exceed 200% of the FPL will pay a share of the premium. The premium share member will pay the share of the premium depending on the number of eligible individuals in the household, and the gross household income.
   1. For 1 eligible household member, the premium share will be equal to 2.5% of the gross household income;
   2. For 2 eligible household members, the premium share will be equal to 3.0% of the gross household income;
   3. For 3 eligible household members, the premium share will be equal to 3.5% of the gross household income;
   4. For 4 or more household members, the premium share will be equal to 4% of the gross household income.

C. Premium payment for chronically ill person between 200% and 400% of FPL. The PSA will require the chronically ill enrollees and their household members whose gross household income is between 200% and 400% of the FPL to pay the full premium as established by the PSA.

D. Premium payment schedule. The PSA requires that upon conditional approval of the application, the Premium Share member must pay the premium for the 1st 2 months of coverage. If the PSA receives the premium payment on or before the 15th day of the month, enrollment will begin on the 1st day of the next month. If the PSA receives the premium payment after the 15th day of the month, coverage begins on the 1st day of the 2nd month.

E. When and how to submit premium. The Premium Share member shall submit their monthly premium payment to the PSA at least 30 days in advance of the coverage month.
   1. All premiums paid in advance by the Premium Share member are non-refundable, unless the member is disenrolled prior to the month of coverage.
   2. A Premium Share member's monthly premium must be paid with sufficient funds in the form of a:
      a. Cashier's check;
      b. Personal check; or
      c. Money order.

F. Newborns. All newborns shall be enrolled within 31 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the PSA within 31 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

G. Copayment requirements. A Premium Share member shall pay the following copayments as specified in Laws 1997, Ch. 186 § 3:
   1. $10 for each physician visit;
   2. $25 for each emergency room visit. This fee shall be waived if the person is admitted to the hospital;
   3. $50 for each inpatient stay;
   4. $50 for each emergency room visit that is for a nonemergency situation;
   5. $3 for each prescription that is filled with a generic drug, and 50% of the cost of each prescription that is filled with a brand name pharmaceutical, unless a generic drug is unavailable or not medically appropriate, in which case the enrollee shall pay $3 for each prescription;
   6. $8 for each laboratory visit;
   7. $8 for each x-ray service;
   8. $50 for each behavioral health admission to an inpatient behavioral facility. Enrollees are eligible for a maximum of 30 days of inpatient behavioral health services annually;
   9. $10 for individual outpatient behavioral health services. Enrollees are eligible for a maximum of 30 outpatient behavioral health visits annually;
   10. $5 for outpatient behavioral health group services; and
   11. The full cost of any nonemergency transportation.

H. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay copayments in full at the time service is rendered as specified in Laws 1997, Ch. 186 § 3.

R9-30-702. The PSA's Scope of Liability; The PSA's Payment Responsibilities to Contractors

A. Liability for covered services. The the AHCCCS Administration and the PSA shall have no liability for the provision of covered services or for the completion of a plan of treatment to a Premium Share member beyond the date of termination of the individual's eligibility or enrollment.

B. Subcontracts liability. The AHCCCS Administration and the PSA shall have no liability for subcontracts that a contractor may execute with other parties for the provision of:
   1. Administrative or management services;
   2. Medical services;
   3. Covered health care services; or
   4. For any other purpose.

C. Contractor's liability for costs. The contractor shall indemnify and hold the AHCCCS Administration and the PSA harmless from any and all liability arising from the contractor's subcontracts, and shall be responsible for:
   1. All costs of defense of any litigation concerning the liability; and
   2. Satisfaction in full of any judgment entered against the AHCCCS Administration and the PSA in litigation involving the contractor's subcontracts.

D. Capitation rates. The PSA shall establish actuarially sound capitation rates as specified in Laws 1997, Ch. 186 § 3. The PSA may adjust the initial capitation rates, except that any increase exceeding 10% of the established rate must 1st be reviewed by the oversight committee as specified in Laws 1997, Ch. 186 § 3.

E. Payments. The PSA shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the PSA and in accordance with these rules.

F. Medical financial risk. The PSA will limit the medical financial risk to contractors associated with the PSDP through a reconciliation risk sharing arrangement as specified in contract.

G. Payments made on behalf of a contractor; recovery of indebtedness. The PSA may make payments on behalf of a contract in order to prevent a suspension or termination or services as specified in A.A.C. R9-22-713.

H. Specialty contracts and payments. The PSA may at any time negotiate or contract for specialty contracts on behalf of providers, and noncontracting providers. The PSA and a contractor shall meet the requirements in A.A.C. R9-22-716.

I. Charges against a Premium Share member. A contractor, subcontractor, or other provider of care of services shall not:

1. Charge;
2. Submit a claim; or
3. Demand or otherwise collect payment from a Premium Share member or person acting on behalf of a Premium Share member for any covered service except to collect an authorized copayment or payment for a non-covered service. A prepaid capitated contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost for providing the service.

J. Collecting payment. Except for copayments under R9-30-701(F), a provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be a Premium Share member without 1st receiving verification from the PSA that the individual was ineligible for PSDP on the date of service or that the services provided were not covered by PSDP.

K. Premium Share member withheld information. The prohibition in Section (J) shall not apply if the PSA determines that the Premium Share member willfully withheld information pertaining to the Premium Share member's enrollment with a contractor. A prepaid capitated contractor shall have the right to recover from a Premium Share member that portion of payment made by a 3rd-party to the Premium Share member when the payment duplicates the PSDP benefits and has not been assigned to the contractor.

R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

A. General responsibilities. A provider shall submit to a contractor all claims for services rendered to a Premium Share member enrolled with the contractor. A contractor shall pay for all admissions and covered services provided to a Premium Share member when the admissions or covered services have been arranged and necessary authorization has been obtained by:
1. A contractor's agent or employee;
2. A subcontracting provider; or
3. Other individual acting on the contractor's behalf.

B. Claims.
1. Time-frame to pay a claim. A contractor shall reimburse subcontracting and noncontracting providers for the provision of covered health care services to a Premium Share member either:
   a. Within the time period specified by contract between a contractor and a subcontracting entity; or
   b. Within 60 days of receipt of a clean claim, if a time period is not specified in contract; or
   c. For a hospital claim, a contractor shall pay a noncontracting provider for inpatient hospital and outpatient hospital services according to the quick pay discount and slow pay penalties as specified in A.R.S. § 36-2903.01(J).
2. When a contractor is not required to pay a claim. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service, or that is submitted as a clean claim more than 12 months after the date of service.
3. Inpatient or outpatient hospital claim. A contractor shall pay the hospitals in accordance with:
   a. How a hospital claim is processed according to A.A.C. R9-22-705;
   b. What personal care items are covered according to A.A.C. R9-22-717; and
   c. What hospital supplies and equipment are covered according to A.A.C. R9-22-717.
4. Review of hospital claims. If a contractor and a hospital do not agree on reimbursement levels, terms and conditions, the requirements specified in A.A.C. R9-22-705 shall apply.
5. Denial and rights of a claimant. A contractor shall provide written notice to a provider whose claim is denied or reduced by the contractor within 60 days of receipt of a claim. This notice shall include a statement describing the provider's right to:
   a. Grieve the contractor's rejection or reduction of the claim; and
   b. Submit a grievance in accordance with A.A.C. R9-22-804.

C. Reimbursement.
1. In-state inpatient hospital reimbursement. A contractor shall reimburse an in-state subcontractor and noncontracting provider for the provision of inpatient hospital services. The contractor may choose among the following reimbursement methodologies depending on the county in which the services are provided.
   a. Maricopa and Pima counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. Reimbursement based on the pilot program described in A.A.C. R9-22-718.
   b. Cochise and Pinal counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. The prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712.
2. Payment for emergency services and subsequent care. A contractor shall pay for all emergency care services provided to a Premium Share member by subcontracting and noncontracting providers when a service:
   a. Conforms to the notification requirements in R9-30-Article 2;
   b. Conforms to the definition of emergency medical services defined in R9-22-Article 1;
   c. Meets the requirements in A.A.C. R9-22-709 - Contractor's Liability for Hospital for the Provision of Emergency and Subsequent Care; and
   d. Is provided in the most appropriate, cost-effective, and least restrictive setting.
3. Observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days that do not result in an admission at:
   a. A rate specified by subcontract; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.
4. Outpatient hospital reimbursement. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either:
   a. A rate specified by subcontract. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

5. Out-of-state hospital reimbursement. A contractor shall reimburse an out-of-state hospital for the provision of inpatient and outpatient hospital services at:
   a. The lower of the negotiated discounted rates; or
   b. 80% of billed charges.

D. Transfer of payments. The PSA or a contractor shall meet the requirements in A.A.C. R9-22-704.